

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00684

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Md.</b>		c. LENGTH OF STAY IN 1b <b>20 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Week's Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piedmont</b>	
f. STREET ADDRESS <b>4 Childs Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isaac</b>		First <b>Adams</b>	Middle <b> </b>
4. DATE OF DEATH <b>1 Nov. 12 1881</b>		Month <b>1</b>	Day <b>4</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Nov. 12 1881</b>		9. AGE (In years last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months <b> </b> Days <b> </b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubber Plant</b>	11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Adams</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Bane</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>296-01-2429</b>		17. INFORMANT <b>Vause Adams-Westernport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <b>James H. Feaster, Jr., M. D.</b>	
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		1-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/7/60</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Philos</b>		22d. LOCATION (City, town, or county) <b>Westernport</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Bonal</i>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

**REGULATORY EXAMINER - CHIEF EXAMINER OF BANKS**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G255 2-8-60 et

00685

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Mt. Lake Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weeks Nursing Home</b>		d. STREET ADDRESS <b>Weeks Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Bertha</b>	Middle <b>Bittinger</b>	Last <b>Biggs</b>	4. DATE OF DEATH Month <b>January</b>	Day <b>30,</b>	Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 8, 1887</b>	9. AGE (In years to birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Perdy Bittinger</b>			14. MOTHER'S MAIDEN NAME <b>Martha Ellen Speicher</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Ray E. Bittinger</b>		Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>							
12-24 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>77 Oak St., Oakland, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February</b> , 19 <b>57</b> to <b>January 30, 1960</b> , that I last saw the deceased alive on <b>January 30, 1960</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>77 Oak St., Oakland, Md.</b>							
DATE SIGNED <b>31 Jan 60</b>							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>							
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/2/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Gorman, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>He Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>		24b. REGISTRAR'S SIGNATURE	
				DATE <b>FEB 3 '60</b>			

MANUFACTURE OF INK—PAINT—GLASS

CERTIFICATE OF DESIGN

1870

NO. 100

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0701 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jennings, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LLOYD</b>		First <b>ALBERT</b>	Middle <b>BUTTINGER</b>
4. DATE OF DEATH <b>Jan. 11 1960</b>	Month <b>Jan.</b>	Day <b>11</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1898</b>
9. AGE (In years lost birthday) <b>61</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Road Const.</b>	12. BIRTHPLACE (State or foreign country) <b>Jennings, Garrett Co.</b>
13. FATHER'S NAME <b>Charles Bittinger</b>	14. MOTHER'S MAIDEN NAME <b>Mary Hoover</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Lucille Bittinger, Jennings, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <b>Coronomatosis</b> DUE TO <b>Gastric carcinoma</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 11, 1960</b> , to <b>Jan. 11, 1960</b> , that I last saw the deceased alive on <b>Jan. 11, 1960</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Bumby M</i>		ADDRESS (Street, city or town, state) <b>Maryland Mayfield, Pa.</b>	
PHYSICIAN'S NAME (Type) <b>Don J. Newman</b>		DATE SIGNED <b>1-12-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Bittinger</b>	22d. LOCATION (City, town, or county) (State) <b>Bittinger, Garrett Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Newman</b>	ADDRESS <b>Grantsville, Md.</b>	24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00687

## 0792 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>GARRETT</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>RURAL</i> <i>GRANTSVILLE, MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>GOODWILL MENNONITE HOME</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X GRANTSVILLE, MD</i>	
e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
<i>EARL WILLIAM BURKHOLDER</i>		<i>JAN 15 1960</i>	
5. SEX		6. COLOR OR RACE	
<i>MALE</i>		<i>WHITE</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input checked="" type="checkbox"/>	
JUNE 4, 1900		9. AGE (In years last birthday) yrs. <i>59</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BRICK PLANT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DISABILITY SS.</i>	
11. BIRTHPLACE (State or foreign country) <i>GARRETT Co., MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE BURKHOLDER</i>		14. MOTHER'S MAIDEN NAME <i>AGNES METZ</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		INFORMANT <i>Mary Bettinger, Grantsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO <i>Cerebral thromboses</i>			
(c) DUE TO <i>Arterosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterosclerotic heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Leonard L. Rock, M.D. 209 North St Meyerdale Pa</i>	
ACTUAL SIGNATURE <i>Leonard L. Rock, M.D.</i>		DATE SIGNED <i>1-19-60</i>	
PHYSICIAN'S NAME (Type) <i>Leonard L. Rock, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/19/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>GRANTSVILLE</i>		22d. LOCATION (City, town, or county) <i>GRANTSVILLE GARRETT Co., MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman, GRANTSVILLE, MD</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 22 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Christine S. Hunt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
STADIA STADIUMS - 5070

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0687 CERTIFICATE OF DEATH

00688

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland.	b. COUNTY Garrett
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Oakland,		c. LENGTH OF STAY IN lb 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		d. STREET ADDRESS 2 Mi. So. Oakland, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Croner	Middle M.	Last Calhoun	4. DATE OF DEATH January 25,	Month Year 19 60
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 2, 1881	9. AGE (In years 78 birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John W. Calhoun	14. MOTHER'S MAIDEN NAME Sarah Nair
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 217-01-8318	17. INFORMANT Mrs. C. M. Calhoun	Address Oakland, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)	Myocardial Infarction, Acute INTERVAL BETWEEN ONSET AND DEATH 5 minutes
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 77 Oak St., Oakland, Md.	(County)	(State)

21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>January 25, 1960</u> , that I last saw the deceased alive on <u>January 19, 1960</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <u>77 Oak St., Oakland, Md.</u>	DATE SIGNED <u>26 Jan 60</u>
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ACTUAL SIGNATURE <u>Herbert H. Leighton</u>	PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.	77 Oak St., Oakland, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/1960	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.	22d. LOCATION (City, town, or county) near Mt. Lake Park, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Herb Leighton</u>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Keane</u>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0688 CERTIFICATE OF DEATH

Reg. Dist. No.

00689

1. PLACE OF DEATH a. COUNTY <b>GARRETT COUNTY</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND, MARYLAND</b>		c. LENGTH OF STAY IN 1b RURAL		b. COUNTY <b>GARRETT</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>			e. STREET ADDRESS <b>RURAL SWANTON</b>		
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)	First <b>EDDIE</b>	Middle <b>JAMES</b>	Last <b>CHRISTENOPHER</b>	4. DATE OF DEATH Month <b>JANUARY</b>	Day <b>4</b>	Year <b>1960</b>
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S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>7-28-59</b>	9. AGE (In years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>7</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>OAKLAND, MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13. FATHER'S NAME <b>CHRISTENOPHER, JAMES HOWARD</b>	14. MOTHER'S MAIDEN NAME <b>TICHNELL, DORIS B.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT (FATHER) <b>JAMES HOWARD CHRISTENOPHER</b>	Address <b>SWANTON, MD.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>501X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Secondary to Congenital heart disease</b> DUE TO (c) <b>13 months</b>	<b>12 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	5 days

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7-28-59</b>	20f. (City or town) <b>OAKLAND</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
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21. I certify that I attended the deceased from **7-28-59** to **1-4-60**, that I last saw the deceased alive on **7-4-60**, and that death occurred at **6:08 P.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE *James H. Feaster Jr.* M.D. **58-2-107 OAKLAND - 1-4-60**

PHYSICIAN'S NAME (Type) DR. JAMES H. FEASTER JR.

OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/6/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Tichnell</b>	22d. LOCATION (City, town, or county) <b>Swanton</b>	(State) <b>Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>El. Bowal - Westernport, MD</i>	ADDRESS <b>2070242XV7</b>	24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>	24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>
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07. 東京オリンピック開幕式の音楽を担当する作曲家は誰ですか？

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00690

## 0689 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Oakland DOA		b. COUNTY		Garrett		
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Crellin		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Garrett County Memorial Hospital		d. STREET ADDRESS		/		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Sandra	Middle Kay	Last Crosco	4. DATE OF DEATH	Month 1	Day 13	Year 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 16	Hours Min.
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 27, 1959				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
none		none		Oakland Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Clarence Crosco		Marie Sirbaugh						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		none		Clarence Crosco		Crellin, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pneumonitis, S. Influenzae 4 days						
490 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
{		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		77721-11-740						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from Dec 15, 1960, to 1-12, 1960, that I last saw the deceased alive on 1-11, 1960, and that death occurred at 4:30 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE James H. Foster, M.D. ADDRESS (Street, city or town, state) 5821 St. Oakland, Md. DATE SIGNED 1-13-60								
PHYSICIAN'S NAME (Type)		James H. Foster, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
burial		1/14/60		Ashby Cemetery		Crellin, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home		Oakland, Maryland		JAN 18 '60		Arthur S. Kraus		
DATE								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

2070368XV4

STATE GOVERNMENT OF CALIFORNIA - SAN FRANCISCO

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD JAMES O'NEILL	65	M	HEART DISEASE
ADDRESS	PLACE OF DEATH	TIME OF DEATH	NAME OF DOCTOR
1010 BOSTON AVENUE	HOSPITAL	10:00 P.M.	DR. RICHARD L. HARRIS
STANFORD, CALIFORNIA	STANFORD		
RELATIONSHIP TO DECEASED	NAME AND ADDRESS OF REPORTER	NAME OF CLERK	NAME OF DIRECTOR
SPOUSE	DR. RICHARD L. HARRIS 1010 BOSTON AVENUE STANFORD, CALIFORNIA	CLERK	DIRECTOR
DATE OF DEATH	TIME OF DEATH	NAME OF CLERK	NAME OF DIRECTOR
NOVEMBER 21, 1967	10:00 P.M.	CLERK	DIRECTOR
APPROVAL	APPROVAL	APPROVAL	APPROVAL
DR. RICHARD L. HARRIS	DR. RICHARD L. HARRIS	CLERK	DIRECTOR
1010 BOSTON AVENUE	1010 BOSTON AVENUE	CLERK	DIRECTOR
STANFORD, CALIFORNIA	STANFORD, CALIFORNIA	CLERK	DIRECTOR

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG254 1-12-60 et

0690

## CERTIFICATE OF DEATH

Reg. Dist. No.

00691

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of either death: Page 4  
 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oakland,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Evans Nursing Home</b>				d. STREET ADDRESS <b>Not given</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. STREET ADDRESS <b>Evans Nursing Home</b>							
3. NAME OF DECEASED (Type or print)		First <b>Ard</b>	Middle <b>Howard</b>	Last <b>Crossland</b>	4. DATE OF DEATH Month <b>January</b>	Day <b>5,</b>	Year <b>1960</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 21, 1881</b>	9. AGE (In years lost/birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Crossland</b>		14. MOTHER'S MAIDEN NAME <b>Jane Yokum</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-26-2634</b>		17. INFORMANT <b>Mrs. Emory Freeland</b>		Address <b>Springfield, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronch o Pneumonia (Related)</b> DUE TO (c) <b>5 days</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardio-Vascular Renal Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1958</b> to <b>Jan 5, 1960</b> , that I last saw the deceased alive on <b>Jan 5, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kitzmiller, Md.</b>		DATE SIGNED <b>1/5/60</b>					
ACTUAL SIGNATURE <b>Ralph Calandrella</b>		PHYSICIAN'S NAME (Type) <b>Ralph Calandrella, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00692

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the Office of Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		0703 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>Harrison</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg,</b>		d. STREET ADDRESS <b>413 North 7th Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #50, 12 Mi. S. Oakland</b>				d. STREET ADDRESS <b>413 North 7th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Jerome</b>		First <b>James</b>	Middle <b>Donnellon</b>	Last <b>Donnellon</b>	4. DATE OF DEATH <b>Jan 18 1960</b>	Month <b>Jan</b>	Day <b>18</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 9, 1916</b>	9. AGE (In years from birthdate) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Wrecker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage,</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Donnellon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hikenbach</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W W #2</b>		17. INFORMANT <b>092-10-9715 John Loria</b>	Address <b>Clarksburg, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured skull</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>								
816 X DUE TO <b>Fractured arms</b> " "								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured right leg</b> " "								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Head on auto truck collision Rt. 50 Nr. Oakland, Md.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour <b>9:30</b> p.m. <b>1-18-60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Rural Oakland Garr. Md.</b>	(County) <b>Garr.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> DATE SIGNED <b>1-18-60</b>								
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. FUNERAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/1960</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Cross</b>		22d. LOCATION (City, town, or county) <b>Clarksburg, W. Va.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <i>James S. Kline</i>		

ВІДВОДИТЬСЯ ВІД ТЕРМІНОВОСТІ СТАДІОНА  
НТАЄ ЧІСЛЕНІ ПРИМАХУЧІ

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0691

## CERTIFICATE OF DEATH

Reg. Dist. No.

00693

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Deer Park McHenry</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>2 Mi East McHenry</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ida</b>	Middle <b>May</b>	Last <b>Glotfelty</b>	4. DATE OF DEATH Month <b>January</b>	Day <b>13</b>	Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 18, 1873</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>86</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home making</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Fazenbaker</b>			14. MOTHER'S MAIDEN NAME <b>Ann Burton</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Rosa M. Harvey, Deer Park, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, b. bronchitis</b>		DUE TO <b>260X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Diabetes mellitus</b>		DUE TO		3 yrs.			
(c) <b>Anemia - generalized</b>				4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , 19, to <b>1-13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-12</b> , 19 <b>60</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jean H. Feaster Jr.</i>		ADDRESS (Street, city or town, state) <b>58 21st Street Oakland, Md.</b>		DATE SIGNED <b>1-13-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Thayerville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arnold J. Miller</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0632

## CERTIFICATE OF DEATH

Reg. Dist. No.

00694

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELVIN RICHARD HANLIN		4. DATE OF DEATH JANUARY 22 19 60	Month Day Year
5. SEX M	6. COLOR OR RACE W WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 4, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. HANLIN		14. MOTHER'S MAIDEN NAME Cora CORA A. Secrist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no 705-10-6061 17. INFORMANT GEORGE A. HANLIN R #1 - ELK GARDEN, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO <i>Carcinomatosis, Pulmonary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Carcinoma of Bladder</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Andrew E. Mance</i>	M.D.	OAKLAND, MARYLAND	<i>Feb. 23, 1960</i>
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1960	22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery
22d. LOCATION (City, town, or county) Elk Garden, W. Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>		24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
ADDRESS Oakland, Md.			

## WISCONSIN STATE DEPARTMENT OF HIGHWAYS - DIVISION 12

## 003 - CERTIFICATE OF DELIVERY

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the register within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

00695

**0704 CERTIFICATE OF DEATH**

Item#7-FilmG254-1/15/60-mb

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	GARRETT MARYLAND FRIENDSVILLE NONE	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MD COUNTY GARRETT FRIENDSVILLE - Md. (If rural give location) G.F.D.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (in this place)	STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE</b> (Month) (Day) (Year)	
(First) ROBERT - A - Hock.		OF DEATH 1 - 9 - 1960	
<b>5. SEX</b> M.	<b>6. COLOR OR RACE</b> WHITE	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married</b>	<b>8. DATE OF BIRTH</b> 1-15 1865 94 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.
Coal Miner		Mining	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
John Hock		Illinois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		12. CITIZEN OF WHAT COUNTRY?	
(If Yes, give war or dates of service)		US	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
No Number		Elizabeth Martin	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.0 IMMEDIATE CAUSE</b> (A) <u>Cardio Respiratory Failure</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>Arteriosclerotic Heart Disease</u>			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aging.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 1958</u> , to <u>Jan 1960</u> , that I last saw the deceased alive on <u>1-8-1960</u> , and that death occurred at <u>1140A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ledro Rivera</u> ADDRESS (Street, city, town, state) <u>M.D. Friendsville, Md.</u> DATE SIGNED <u>Jan. 19 - 1960</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIY	LOCATION (City, town, or county) (State)
BURIAL	1-11-60	Stile Cemetery	Friendsville Md.
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
JAN 12 '60	Charles S. Kraus	H.H. Rodahaver - Markleysburg Pa.	

ST. ALBOMITZAS-NTJAH TO TENTHAWID STATE CHAUVIN

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G256 2-11-60 et

## 0705 CERTIFICATE OF DEATH

00696

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. LENGTH OF STAY IN lb 6 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park				
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Harry	Middle Jerolman			
4. DATE OF DEATH		Month 1	Day 31			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Male		White	B. DATE OF BIRTH 9/20/1875			
9. AGE (In years less birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS. Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appliance washer		10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) unk.			
12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO. unk.	17. INFORMANT Edith Weber Mt. Lake Park, Maryland			
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first. (b) Anteroseptosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 months Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Upper Respiratory Infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) I was sick				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unk.	20f. (City or town) unk.	(County)	(State)
21. I certify that I attended the deceased from 2-21, 1957, to 1-29, 1960, that I last saw the deceased alive on 1-29, 1960, and that death occurred at 712 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 2-1-60		
ACTUAL SIGNATURE <i>James H. Fenster</i>		M.D. 5821st Oakland Rd				
PHYSICIAN'S NAME (Type) James H. Fenster, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/3/60	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery	22d. LOCATION (City, town, or county) Oakland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR FEB 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

00697

**0693 CERTIFICATE OF DEATH**

**Reg. Dist. No.**

1. PLACE OF DEATH o. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		
GARRETT MARYLAND			WEST VIRGINIA LIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
OAKLAND		18 days		MORGANTOWN 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS 181 Walnut St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First CECIL	Middle MILLER	Lost LAMB	4. DATE OF DEATH JANUARY 24 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAR. 11, 1888	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME J. M. LAMB			14. MOTHER'S MAIDEN NAME ETTA MILLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address GRAHAM WEEKS - WEEKS NURSING HOME, OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meconium Thrombosis - Gangrene of Bowel 2 days 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bilateral Pneumonia - Non-sight lung 2 weeks DUE TO } (c) Lung Abscess - Right - Large Multiple 1 Month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Emphysema					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1957, to January 27, 1960, that I last saw the deceased alive on January 27, 1960, and that death occurred at 7:00 PM, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) M.D. 77 Oak St. Oakland, Md. 23 Jan 60					
DATE SIGNED					
ACTUAL SIGNATURE Herbert H. Leighton					
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/27/1960		22c. NAME OF CEMETERY OR CREMATORIAL East Oak Grove Cemetery, Morgantown, W. Va.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Leighton Oakland, Md.					
24a. REC'D BY REGISTRAR DATE JAN 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kress			

BY ECONOMIC POLICY OF STATE OWNERSHIP

CONTINUOUS DEBT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00698

## 0706 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Mt. Lake Park		6 mos.		Oakland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				
Elder Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
Margaret				Lawton	1	27	1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
Female	White	July 24, 1889		70				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Bookkeeping		Garage		Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Samuel Lawton		Susan Harne						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		214-12-3034		Mrs. Bertie Thrasher		Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Multiple Sclerosis					13 years	
481X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO						
{ (b)		DUE TO						
{ (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from Jan. 28, 1955, to January 27, 1960, that I last saw the deceased alive on 1/22, 1960, and that death occurred at 7:35 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE		101 THIRD STREET					ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		OAKLAND, MARYLAND					DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/30/60		22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Hinnich Funeral Home		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Mance		

[ 5 ]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00699

0707

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Mi. S. Oakland, Md.		d. STREET ADDRESS 5 Mi. S. Oakland, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Noah		First	Middle S.	Last Lichty	4. DATE OF DEATH January 16, 1960	Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 25, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Simon Lichty		14. MOTHER'S MAIDEN NAME Sarah Beachy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-38-5927		17. INFORMANT Mrs. Noah Lichty		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebro-Vascular disease arterio sclerosis -				INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>Jan. 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan. 15</u> , 19 <u>60</u> , and that death occurred at <u>8:15A</u> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u>		DATE SIGNED <u>16 Jan. 60</u>	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/18/1960		22b. DATE THEREOF 1/18/1960		22c. NAME OF CEMETERY OR CREMATORIUM Slabaugh Cemetery		22d. LOCATION (City, town, or county) (State) near Gortner, Garrett Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JAN 19 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0694 CERTIFICATE OF DEATH**

00700

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN lb <b>27 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oakland,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>High Street</b>		d. STREET ADDRESS <b>High Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Christina McGettigan</b>	Middle <b>Mattingly</b>	Last	4. DATE OF DEATH <b>January 27,</b>	Month Day Year 19 60	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1876</b>	9. AGE (In years (att. birthday) yrs. <b>83</b>	IF UNDER 1 YEAR Months <b>83</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson McGettigan</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Echard</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Mrs. Teresa Bittinger</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREm.2</b>						<b>10 days</b>	
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) <b>Cerebral Vascular Accident</b>					<b>14 days</b>
		DUE TO (c) <b>Anemia clausa</b>					<b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 23</b> , 19 <b>60</b> to <b>1-23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-23</b> , 19 <b>60</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> M.D. <b>58 2101 Oakland</b> 1-30-60						ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>						DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Hoyes Catholic Cemetery, Hoyes, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>He, Reighlton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

00701

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		0635 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b>		b. COUNTY <b>Preston</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aurora</b>		d. STREET ADDRESS <b>85x3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>LeRoy</b>	Middle	Last <b>Redmond, Jr.</b>	4. DATE OF DEATH <b>January 14, 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Dec. 16, 1955</b>	9. AGE (In years lost birthday) <b>4 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>LeRoy Redmond, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Joanna Veneer</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Mrs. Bessie Deakins</b>		Address <b>Aurora, W. Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRACHEO-BRONCHITIS, ACUTE,-PNEUMONITIS</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>								
500X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED <b>1-15-60</b>						
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Aurora Cemetery</b>		22d. LOCATION (City, town, or county) <b>Aurora, Preston Co., W. Va.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Keighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Carmer J. Price</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0636

## CERTIFICATE OF DEATH

Reg. Dist. No.

00702

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>1 hr. 45 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Route # 1 Box 101</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Dorsey</b>	Middle <b>Carlton</b>	Last <b>Rumer</b>	4. DATE OF DEATH Month <b>January</b>	Day <b>25</b>	Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-27-10</b>	9. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Brookside, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joe Rumer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah, Elizabeth Rendree</b>		Address <b>Rt. # 1 Box 101 Oakland, Maryland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>"Wife" Emma Nair Rumer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerosis, Advanced</b>						Years <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						Years <b>4 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/21/49</b> , 1949, to <b>1-25-</b> , 1960, that I last saw the deceased alive on <b>1-25-</b> , 1960, and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. 58 21st St. Oakland, Md.</b>					
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		DATE SIGNED <b>1-26-60</b>					
PHYSICIAN'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>		Oakland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/60</b>		22c. NAME OF CEMETERY OR CREATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) <b>Oakland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Minerich Funeral Oakland, Md.</b>		ADDRESS <b>Minerich Funeral Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0697 CERTIFICATE OF DEATH

Reg. Dist. No. **00703**

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN lb <b>20 minutes</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Willie</b>	Middle <b>Elwood</b>	Last <b>Stottlemeyer</b>	4. DATE OF DEATH Month <b>January</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>August 3, 1905</b>	9. AGE (In years last birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Swanton, Maryland</b>	
13. FATHER'S NAME <b>Stottlemeyer, Sheridan</b>		14. MOTHER'S MAIDEN NAME <b>King, Emma</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-14-7119</b>		17. INFORMANT Address Box 178 <b>"Wife" Polly Anna Stottlemeyer, Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <b>11/23/59</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/23/59</b> , 1959, to <b>1-27-</b> , 1960, that I last saw the deceased alive on <b>11/23/59</b> , 1959, and that death occurred at <b>8:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>					
ACTUAL SIGNATURE <b>Joseph Alvarez</b>					
PHYSICIAN'S NAME (Type) <b>Joseph Alvarez, M. D.</b>					
22o. BURIAL, CREMATION, REBURN (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oakland Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>					
ADDRESS <b>Oakland, Md.</b>					
24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>					
24b. REGISTRAR'S SIGNATURE <b>Curtis J. Alvarez</b>					

20

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0638 CERTIFICATE OF DEATH

Reg. Dist. No.

00704

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingwood</b>		d. STREET ADDRESS <b>85X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Minnie</b>	Middle <b>Wakefield</b>	Last <b>January</b>	4. DATE OF DEATH <b>9</b>	Month <b>1960</b>	Day	Year
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 9, 1879</b>	9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR Months <b>80</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>homemaking</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
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13. FATHER'S NAME <b>Elisha Hartman</b>	14. MOTHER'S MAIDEN NAME <b>Mary Jane Guthrie.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <b>Edward H. Hartman, Brownsville, Pa.</b>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>585x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Peritonitis</b> <b>Cholecystitis</b>		<b>4 days</b>
		<b>10 days</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>White Not white</b>			20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>177 Oak Street, Oakland, Md.</b>	(County) <b>12/1960</b>	(State) <b>Md.</b>
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21. I certify that I attended the deceased from <b>February 19, 1960</b> , to <b>January 19, 1960</b> , that I last saw the deceased alive on <b>January 11, 1960</b> , and that death occurred at <b>1:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>177 Oak Street, Oakland, Md.</b>									
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>	DATE SIGNED <b>12/1960</b>								

PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>	Oakland, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan 14 1960</b>	22b. DATE THEREOF <b>January 14 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Kingwood</b>	22d. LOCATION (City, town, or county) <b>Kingwood</b>	(State) <b>Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Beaman, Kingwood 1000</b>	ADDRESS <b>1113 1/2 Arthur Street, Kingwood, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>12/14/60 Lucy Shaffer</b>	24b. REGISTRAR'S SIGNATURE <b>12/14/60 Lucy Shaffer</b>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0699

## CERTIFICATE OF DEATH

Reg. Dist. No.

00705

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route #2, Oakland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Nellie</b>	Middle <b>Mary</b>	Last <b>Warsaw</b>	4. DATE OF DEATH	Month <b>January</b>	Day <b>28</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 21, 1878</b>	9. AGE (In years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Henry Ritter</b>				14. MOTHER'S MAIDEN NAME <b>Martha Wilt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Boyd Warsaw</b>		Address <b>R. D. Gormanian, W. Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> DUE TO <b>421.4</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Valvular heart disease &amp; hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/16</b> , 19 <b>59</b> , to <b>Jan. 28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>60</b> , and that death occurred at <b>11:25A</b> . From the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>A. E. Mance</i>	M.D.	DATE SIGNED <b>29 Feb 60</b>					
PHYSICIAN'S NAME (Type) <b>Dre. A. E. Mance, M. D.</b>		Oakland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (If city) <b>Burial</b>		22b. DATE THEREOF <b>1/31/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Red House Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00706

Reg. Dist. No.

0708

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Be 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oakland,</b>		d. STREET ADDRESS <b>Route #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #1</b>				d. STREET ADDRESS <b>Route #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lawrence</b>	Middle <b>Edward</b>	Last <b>Wilhelm</b>	4. DATE OF DEATH	Month <b>January</b>	Day <b>2,</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1932</b>	9. AGE (In years (birthday) <b>27</b> yrs.)	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Cutter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frank G. Wilhelm</b>	14. MOTHER'S MAIDEN NAME <b>Blanche Virginia Kisner</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>Korean</b>	17. INFORMANT <b>233-48-7210 Mrs. Nancy Wilhelm, R 1, Oakland, Md.</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>					
912.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)							
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck on rt. side of head by a saw blade from power saw.</b>					
20c. TIME OF INJURY Hour <b>3</b>	Month, Day, Year <b>1-2- 1960</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	20f. (City or town) <b>Rural, Oakland Garr. Md.</b>	(County) <b>Garr.</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>1-3-60</b>
EXAMINER'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>							
22a. BURIAL, CREMATION (Remove city) <b>Burial</b>		22b. DATE THEREOF <b>1/5/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Terra Alta Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Alta, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leightlon</i>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

**DEPARTMENT OF EDUCATION EXAMINER'S CERTIFICATE OF DEATH**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00707

Reg. Dist. No.

## CERTIFICATE OF DEATH

07-0

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 409 Walnut	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home				d. STREET ADDRESS 409 Walnut		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle	Last Wilkinson	4. DATE OF DEATH Jan. 9	Month	Day	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 25, 1868	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Parker Wilkinson		14. MOTHER'S MAIDEN NAME Margaret Plaskett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT		Address Mrs. Margaret Biggs-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1		DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cerebral Heart Failure Terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 9, 1960, to Jan. 9, 1960, that I last saw the deceased alive on Jan. 9, 1960, and that death occurred at 7:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE E. I. Baumgartner, M. D.				ADDRESS (Street, city or town, state) M.D. 250 E. 1st St.		DATE SIGNED 1/10/60	
PHYSICIAN'S NAME (Type)		E. I. Baumgartner, M. D.		Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/60		22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Beal		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR JAN 15 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

